PATIENT PRE-SCREENING QUESTIONNAIRE

Due to the ongoing COVID-2019 Pandemic, all caregivers/patients are required to complete this form prior to being seen at ARSO Neuro Rehab and Orthopedic Center. Your visit is subject to approval upon completion of this form. Effective immediately, only 1 adult is to accompany our patient visits, accompanying children who are not being seen as patients are also restricted. These rules are being enforced to keep our patients and staff as well as the rest of your loved ones safe and healthy.

	YES	**NO**
Have you been diagnosed with COVID-19 **IF YES WHEN: ___________________**		
Has the patient, caregiver or anyone in your household have travelled **outside the US in the past 2 weeks (14 days)** **IF YES, WHERE _________________________**		
Has the patient, caregiver or anyone in your household have travelled **outside of Maryland in the past 2 weeks (14 days)** **IF YES, WHERE _________________________**		
In the past **2 weeks (14 days)** has the patient, caregiver or anyone in your household had contact with any person **suspected to have contracted coronavirus (COVID-19)**? Including being ***tested*** for COVID-19, & being in ***self isolation*** for COVID-19		
In the past **2 weeks (14 days)** has the patient, caregiver or anyone in your household had contact with any person **confirmed to have contracted coronavirus (COVID-19)**?		
Has the patient or caregiver currently been exposed to someone **with flu-like symptoms (cough, shortness of breath or fever)**		
PLEASE CIRCLE IF SYMPTOMS ARE CURRENTLY BEING EXPERIENCED BY CAREGIVER, PATIENT OR BOTH		
IN THE LAST 72 HOURS HAS THE PATIENT OR CAREGIVER EXPERIENCED		
FEVER greater the 100.4 F (38.0 C)		
COUGHING		
SORETHROAT / LOSS OF SMELL OR TASTE		
DIFFICULTY BREATHING, SHORTNESS OF BREATH OR WHEEZING		
MUSCLE ACHES		
STOMACH PAINS		
VOMITING OR DIARRHEA		
PINK EYE/ RED EYES		
RASH		
FATIGUE OR FEELING UNWELL		

*****Please return this form to the front desk when completed*****

By signing below, you certify that the answers above are true. Failure to answer truthfully or withholding information intentionally will lead to immediate dismissal from our practice and may be subject to applicable laws during this pandemic.

Patient/Caregiver:______________________________ **Date:___________________________**

Caregiver temp:_______________ **Patient temp:________________**

Policies and Patient Consent and Release

Treatment Plan Policy:
Thank you for choosing ARSO Neuro Rehab and orthopedic center for your physical therapy needs. Our vision is to provide specialized Physical therapy services to people to achieve their highest goals and overcome functional limitations. We believe in a customized approach to physical therapy, as no two people are the same. Treatments are individualized to be concise, meaningful, and restorative.

To attain the best possible outcome from your physical therapy treatment plan, it is imperative that you attend all scheduled physical therapy sessions and put in your best effort. Please be aware that your pain may change as you progress through your treatment plan. If you experience more pain, it is critical for you to come in for your scheduled appointment. If your pain is decreasing, it is still important to continue with your established treatment plan to avoid future problems from the injury.

Financial Policy:
As a courtesy, we will bill the primary insurance company for our patients if we are provided with the necessary information. Your insurance is a contract between you, your employer (if applicable) and your insurance company. We are not a party to that contract. Therefore, it is the patient's responsibility to determine what their insurance company allows for therapy, obtain prior approval (if necessary) and follow up with their insurance company on all unpaid visits. **Co-Payments are due at the beginning of each visit.**

Should your insurance deny payment or coverage for any reason, you are responsible for any and all charges billed.

Cancellation Policy: We require 24 hours advance notice for any cancellation. If you are unable to give the 24-hour advance notice or if you do not show for your scheduled appointment, an administrative fee of $75 will be billed to you.

Acknowledgement of Receipt of Notice of Privacy Practices: By my signature below, I acknowledge that I received a copy of the Notice of Privacy Practices for ARSO Neuro Rehab and Orthopedic Center, LLC.

Patient Consent and Release: I understand that I am financially responsible for all charges for service rendered regardless of litigation, insurance reimbursement or pending Loss and Injury claims. I understand the parent accompanying the minor for treatment will be responsible for payment. I request and consent to the performance of evaluation, treatment and procedures. I understand I am free to withdraw my consent and that I may stop treatment or any procedure at any time.

I authorize ARSO Neuro rehab and Orthopedic Center, LLC to release any necessary information requested by my insurance carrier and authorize payment directly to ARSO Neuro rehab and Orthopedic Center, LLC for any benefits available under my insurance plan.

I authorize treatment of the patient named on these Intake Forms and agree to pay all fees and charges for such treatment. I acknowledge, upon request, receipt of a copy of this agreement. I agree to the terms stated on the following form regarding collection fees and charges. I agree to pay attorney fees and court costs, and any finance or interest charges, and an additional 33.33% collection fee of account balance if turned over to a collection agency in addition to the account balance.

____ ________________________
Signature of Patient or Representative Date

*If this acknowledgement is signed by a personal representative on behalf of the patient, then please complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

This form will be retained in your medical record.

New Patient Information (Please Print Clearly)

Patient Name: ____ Sex: Male ___ Female___

Last First M.I.

Address: ____

. Street City State ZIP

Email: ____________________@______________ Date of Birth: _____/_____/_____

Home/Mobile Phone: (_____) _____ - ________ Work Phone: (____) _____ - ________ Ext. _______

Parent or Guardian (If Patient is a minor): ____

Is patient employed? Yes___ No ___ Full-time student ___. Occupation: _____________________________________

Employer or School: ____ Marital Status: Married ___ Single ___ Other ___

Referring Dr: ____ Phone: (____) _____ - _______

Primary Care Physician: ____ Phone: (____) _____ - _______

How did you hear about our office: Website __ Internet __ Sign __ Friend (Who can we thank?) ________________Other ________

Emergency Contact: ____ Phone: (____) _____ - ________

Insurance Information

Primary Insurance Co: ____ Policy ID#: ______________________

Name of Insured: _____________________________________ DOB: ____/____/____ Group ID #: __________________

Secondary Insurance Co: ____ Policy ID#: ______________________

Name of Insured: ____________________________________ DOB: ____/____/____ Group ID #: __________________

Is your injury work related? Yes ___ No ___ Is your injury related to an auto accident? Yes ___ No ___

If your injury is Work Related or an Auto Injury, please complete the following:

Employer at time of Injury: ____ Date of Injury: ____/____/

Employer City, State, Zip: ______________________________________ Employer Phone #: (___) ____ - _________

Insurance Name: ____Claim #: _____________________

Name of Adjuster: ____ Adjuster Phone #: (____) _____ - _______

Health Information

Date of onset of pain or injury: ____/____/____ Height: _________ Weight: __________

How were you injured: ____

Surgeries Performed and Dates (if applicable): ____

Pregnant or possibly pregnant (if applicable): Yes ___ No ___ Do you smoke or use tobacco: Yes ___ No ____

Do you have a history of falls? Yes ____ No ____ If Yes, when was your last fall: __________________

Have you had any diagnostic testing? (Ex. X-ray, CT Scan, MRI, etc.). If so, what are the specific findings/results?

____

Current Medications: ____

What are your Physical Therapy goals? ____

Medical History:

- No previous medical history
- Arthritis - Rheumatoid or OA
- Cardiovascular /heart disease
- Unexplained weight loss/gain
- Bowel/Bladder changes
- Immune Deficiency disease
- Diabetes Mellitus type 1
- Diabetes Mellitus type 2
- Allergies (food or other)
- Surgical history
- Osteoporosis/Osteopenia
- Dizzy Spells
- Previous Physical Therapy
- Psycho-Social (depression, etc.)
- Night pain
- Cancer
- Seizures
- Pacemaker/Implant of any kind
- Other

Please describe: ____

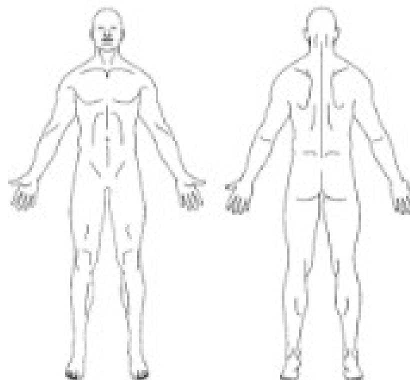
Which of the following functional activities do you have difficulty with due to condition/pain?

- Sleep
- Self-care activities (i.e. dressing/bathing etc.)
- Activities of daily living
- Pushing/pulling/reaching
- Lifting/carrying
- Sitting/standing
- Bending/squatting
- Mobility/walking/stairs (ascending/descending)
- Activities outside your home
- Other: ____________________________

Which of the following makes your pain better?

- Sitting
- Standing
- Walking
- Medication or topical pain cream
- Resting
- Sit to stand.
- Bending
- Laying down/elevating
- Ice or Heat
- Other: ____________________________

Please mark the body diagram where you feel current symptoms of pain with an "x". Mark with an "o" if numbness/tingling/pins symptoms are present on the following figures.



*: PLOF*______________________________